East Kent Hospitals University NHS Foundation Trust

Achalasia

Information for patients

This leaflet is designed for patients who suffer from achalasia and are considering surgery (**Laparoscopic Heller's Cardiomyotomy**) as a treatment for their condition.

What is achalasia?

Achalasia is a condition that makes swallowing difficult.

What causes achalasia?

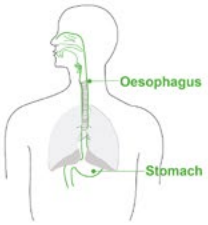
What causes achalasia is not certain but it is a rare condition: there is one case per 100,000 of the UK population diagnosed each year. It affects both men and women equally, usually between the ages of 30 and 60 years.

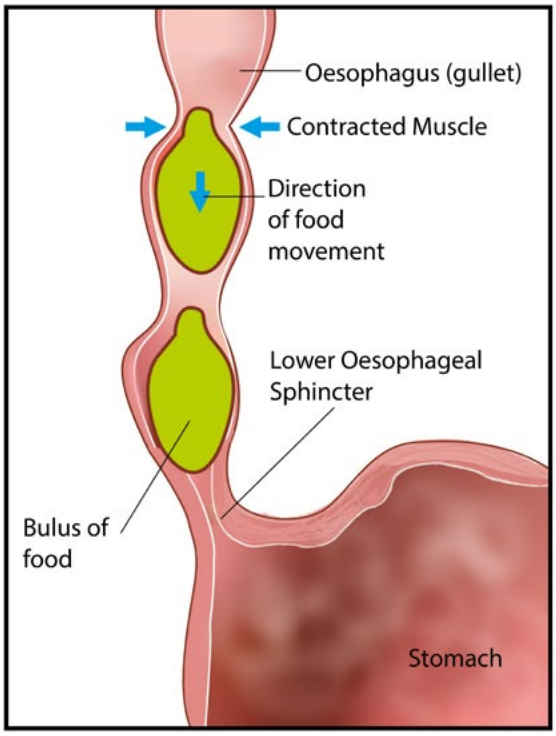
We care

How should my oesophagus work?

The oesophagus (gullet) is a food tube built of muscles that allows food to travel from your mouth into your stomach. Between the lower oesophagus and the stomach there is a valve, known as the lower oesophageal sphincter (LES). This valve relaxes to allow food to pass into your stomach and closes to stop your stomach's contents from refluxing (flowing) back to your oesophagus.

In patients who suffer from achalasia, the muscles of the lower oesophagus do not work properly to allow food to enter the stomach.





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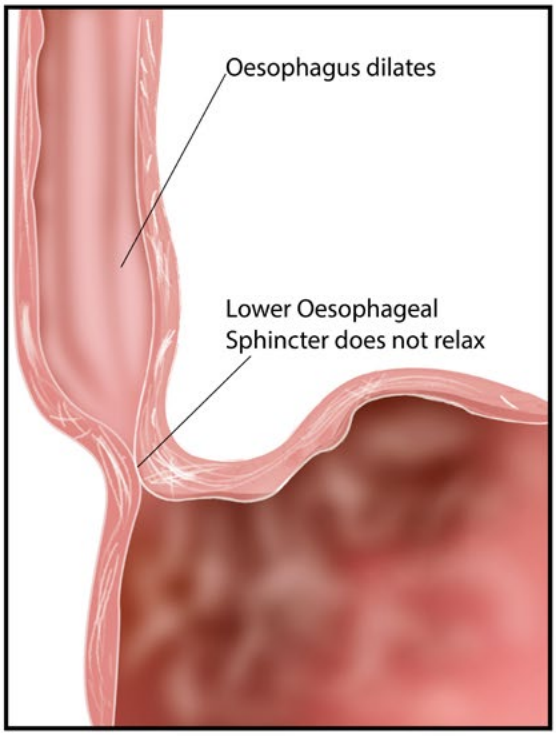


Achalasia

What are the symptoms?

Patients affected by achalasia complain of difficulties swallowing, regurgitation, heartburn, chest pain, and occasional vomiting. In more advance stages of achalasia, malnutrition and weight loss can happen.

How can I help my symptoms?

The London Achalasia Meetup Group have produced the following hints and tips for patients suffering from achalasia.

- Eat little and often.
- Eat slowly and chew well.
- Eat fairly moist food, and try sipping water when eating.
- Beware of eating when feeling stressed.
- Keep good posture with your back straight.
- Relax and drink warm water, this can help avoid spasm and pain.

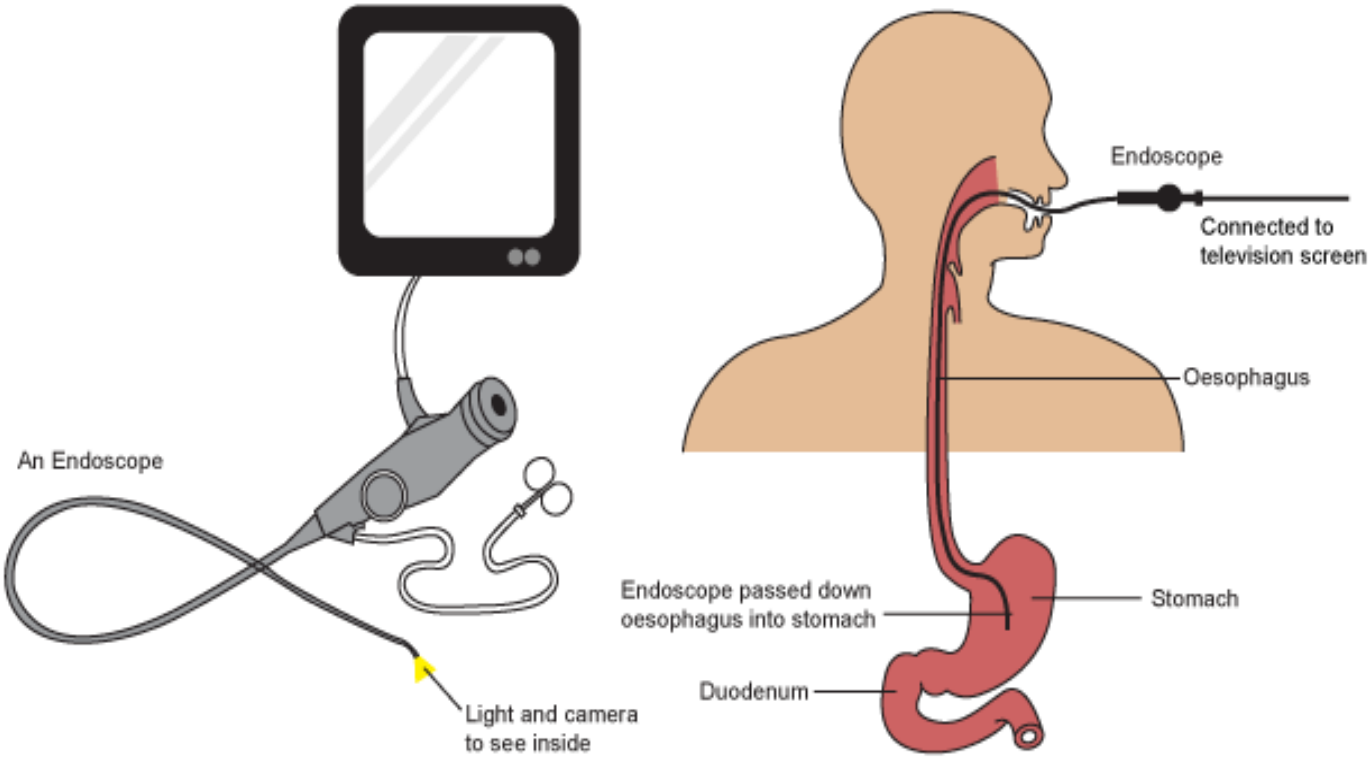
How is achalasia diagnosed?

The most common tests used confirm achalasia are listed below.

- **Barium swallow test**
  You will be asked to drink a liquid that can be seen on x-ray, to see what happens when you swallow. More details are available at: www.nhs.uk/conditions/swallowing-problems-dysphagia/diagnosis or ask a member of staff for a copy of Trust's **Barium swallow/meal/following through** leaflet or go to the Trust's web site www.ekhuft.nhs.uk/radiology/patient-leaflets/

- **Oesophageal manometry study**
  This is a test to measure the pressure in your oesophagus and lower oesophageal sphincter. The test is performed by passing a small tube through your nose into your stomach. The pressure and function of your gullet will be recorded. More details are available at: www.webmd.com/heartburn-gerd/guide/esophageal-manometry#1

- **Diagnostic gastroscopy** (also known as oesophagogastroduodenoscopy)
  This is an internal examination using a long tube (size of your own fingers) with a camera at the end. The camera is passed through your mouth and looks inside your oesophagus. More details are available at: www.nhs.uk/conditions/gastroscopy



Your consultant will discuss each option with you and answer any questions you may have before any of these tests are requested and performed.

What treatments are available?

Patients may be offered one of the following treatments to help their symptoms.

- **Pneumatic dilation**: your lower gullet is stretched using balloons, so that the lower oesophageal sphincter stays open to allow food to pass into your stomach without difficulties. This procedure is performed endoscopically (see Diagnostic gastroscopy on the previous page) under sedation (medicine to make you sleepy and pain-free). The result of the treatment lasts about six months and needs to be repeated. Multiple tries of pneumatic dilation carry a risk of making a hole in your gullet and surgery may be needed to close this. The success rate is 65% (65 out of 100 patients) in five years.

- **Endoscopic Botulinum Toxin (botox) Injection** is performed endoscopically (see Diagnostic gastroscopy) under sedation. Botulinum toxin is injected into your lower oesophageal sphincter to relax your lower oesophagus and allow easy flow of food to your stomach. The result of the treatment lasts about six months and needs to be repeated.

- **Peroral Endoscopic Myotomy (POEM)** is an endoscopic treatment for achalasia, where a small hole is made in your oesophagus through which its muscles are cut. The procedure is performed under general anaesthetic (you will be asleep). POEM is not accompanied by a fundoplication (stomach wrap), with the increased risk of reflux following the procedure remaining a concern.

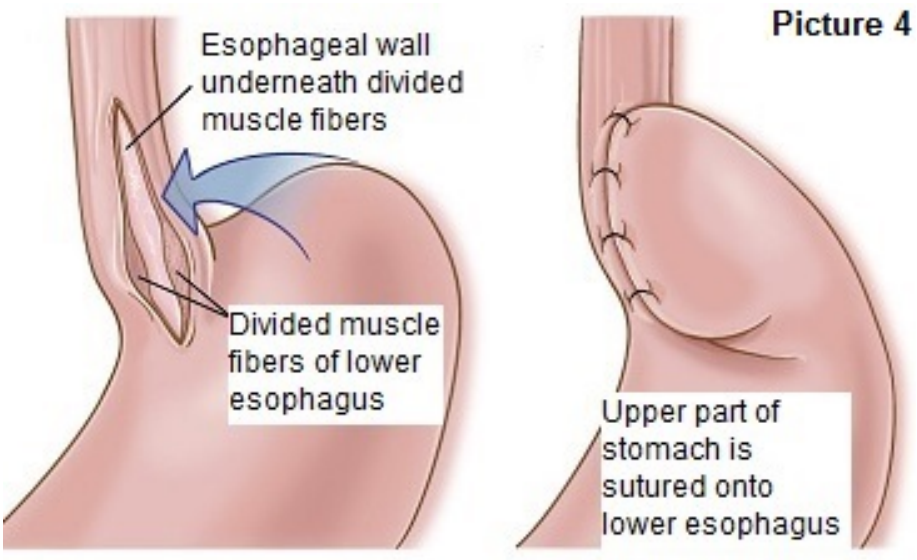
- **Laparoscopic Heller's Cardiomyotomy** is an operation carried out under general anaesthetic (you will be asleep). It involves cutting the muscle layers around your lower oesophagus to allow food to travel into your stomach. The procedure is usually performed laparoscopically (keyhole). Rarely, open surgery may be needed.

  Five small (0.5 to 1cm) incisions (cuts) are made in your abdomen to insert a camera and other laparoscopic instruments. The muscles of your lower oesophagus are divided, taking care to prevent making a hole (perforation) in the inner lining of your oesophagus. However, a perforation can still happen, which is why your surgeon will carry out a leak test before your operation is completed. If this test shows a perforation, your surgeon will repair it.

  To stop reflux of the stomach content back up into your oesophagus, a partial stomach wrap (fundoplication) is created around your oesophagus. The operation can take between two to two and a half hours. More details on Laparoscopic Heller's Cardiomyotomy are available at: www.youtube.com/watch?v=UDrUsL-r6no

The success rate of Heller's Cardiomyotomy is 90% in five years time.

You will be given a choice of treatment options to control your symptoms, which your consultant will discuss with you in detail.



Picture 4

How long will I be in hospital for after my Laparoscopic Heller's Cardiomyotomy?

Patients are usually discharged home one or two days after their operation, once they can eat a soft diet and drink again.

What will happen when I arrive at hospital for my Laparoscopic Heller's Cardiomyotomy?

A letter will be sent to you inviting you to the hospital for your operation. On the day of your surgery you will see your surgeon who will once again explain the procedure and its risk and benefits. You will have a chance to ask any questions, before you are asked for your consent to the treatment. Remember you can withdraw your consent for treatment at any time.

An anaesthetist will also be available to discuss with you the general anaesthetic and answer any questions you may have.

What are the risks and complications?

Like every surgery Laparoscopic Heller's Cardiomyotomy carries risks.

- Infection of the wound, abdomen, chest, or blood.
- Bleeding.
- Injury to the oesophagus, spleen, stomach, pleura (lining of the lungs), or liver.
- Injury to the vagus nerve resulting in poor gastric function.
- Deep vein thrombosis (DVT) which is a clot in the leg veins that can spread to the lungs (pulmonary embolus or PE) and cause breathing difficulties. To reduce the chance of developing DVT or PE anti-thrombosis stockings and calf compression devices will be used during your surgery. Clexane injections will also be prescribed to prevent clots.
- An oesophageal leak may happen during or after your procedure. Intra-operative perforation can be repaired during surgery.
- Post-operative perforation (hole in the gullet) is a serious complication. Depending on the scale of the leak you may need an immediate operation to correct the defect, oesophageal diversion, and placement of a drain in your abdomen. Non-operative options involve a stay in the Critical Care Unit, nil by mouth, antibiotics, and gastric/jejunal access for feeding. In some cases, the use of an oesophageal stent has been proven to work well in treating perforations.
- General risks related to the general anaesthetic (see the **You and your anaesthetic** leaflet. Ask a member of staff for a copy or go to the Trust web site www.ekhuft.nhs.uk/patientinformation).

What happens after surgery?

- The day after your surgery you will have a barium swallow test to check your oesophagus for possible perforation.

- You will be advised to stay on a soft diet for two weeks, avoid beef and bread for six to eight weeks, and to remove fizzy drinks from your diet permanently.

- To start with, swallowing may be difficult, so eat little and often, making sure that you chew your food well.

- The partial fundoplication (stomach wrap) will be acting as a valve to prevent reflux. However, you may still have some reflux, so antacid medication such as Omeprazole or Lansoprasole may be recommended.

When can I start my normal activities?

You will be able to return to your normal activities within six to eight weeks, but your oesophagus will take about six to eight months to heal.

When can I drive again?

You can start to drive again once you are comfortable to use all the controls in your car. You should be able to perform an emergency stop, turn around, and reverse safely. We usually recommend not to drive for three to four days following a keyhole operation and about 10 days after open surgery.

Will I need a follow-up appointment?

A follow-up outpatient appointment will be arranged to review your recovery. You will receive a clinic letter in the post.

Further information

If you have any concerns or queries, please contact the Upper Gastrointestinal Surgery at the William Harvey Hospital on telephone 01233 61 68 72.

This leaflet has been produced with and for patients

If you would like this information in **another language, audio, Braille, Easy Read, or large print** please ask a member of staff. You can ask someone to contact us on your behalf.

Any complaints, comments, concerns, or compliments please speak to your doctor or nurse, or contact the Patient Advice and Liaison Service (PALS) on 01227 78 31 45, or email ekh-tr.pals@nhs.net

Patients should not bring in large sums of money or valuables into hospital. Please note that East Kent Hospitals accepts no responsibility for the loss or damage to personal property, unless the property had been handed in to Trust staff for safe-keeping.

Further patient leaflets are available via the East Kent Hospitals web site www.ekhuft.nhs.uk/patientinformation

Information produced by the Upper Gastrointestinal Surgical Team
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